DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 12/02/12

PRINTED: 10/19/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445291	A. BUILDING _____ B. WING _____	10/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERWIN HEALTH CARE CENTER	100 STALLING LANE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The annual recertification survey and investigation of complaints TN- 30473 and TN-30510 was conducted on October 17, 2012. No deficiencies were cited under 42 PART 483.13, Requirements for Long Term Care for the complaints.	F 000	The MDS for resident # 1 is corrected as of 10/25/12 with the information relating to the tube feeding being appropriately addressed on the MDS. This correction was completed by the MDS Coordinator. All residents who currently have a feeding tube in the facility will have the feeding tube appropriately addressed on the MDS.	11/16/12
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	Policies and Procedures relating to appropriate documentation on the MDS relating to feeding tubes being utilized for adequate nutrition will be reviewed by the ADON on 10/25/12 and revised if necessary. In-service will be completed on 10/25/12 by the ADON relating to the appropriated documentation on the MDS relating to nutritional needs being met by a feeding tube. The In-service will be presented to the Interdisciplinary team who is responsible for completing the MDS. Audits will be completed by the Quality Assurance Nurse on all MDS's of the residents who require a tube feeding to meet their nutritional needs. The audit will validate that the tube feeding is addressed appropriately on each MDS.This audit will be completed by November 2, 2012.This audit will be completed on a monthly basis on an annual or significant change MDS that has been completed and all new residents requiring a tube feeding. The audit will be reviewed by the QA Committee on a monthly basis. The QA Committee members are the Administrator, Assistant-to-the-Administrator, Medical Director, Director of Nursing, Pharmacist, MDS coordinator, Dietary Manager and Quality Assurance Nurse. When areas of focus and trends are identified, action plans will be developed and follow-up will be completed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	10/31/2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to accurately assess the nutritional status for one resident (#1) of thirty residents reviewed. The findings included: Resident #1 was re-admitted to the facility on September 18, 2012, with diagnoses including Nasopharyngeal and Laryngeal Cancer. Review of the medical record revealed while in the hospital the resident had a feeding tube placed on September 17, 2012. Medical record review of the resident's readmission Minimum Data Set (MDS) assessment dated September 25, 2012, revealed the resident's nutritional status was inaccurate. The MDS assessment did not identify the feeding tube or prescribed nocturnal feedings. Medical record review of the resident's Medication Administration Record for September and October 2012 revealed the resident received Jevity 1.5 at 60ml (milliliters) an hour from 8:00 p.m. to 8:00 a.m. each night. The resident continued to take medications and meals orally during the day. Interview with the MDS Coordinator on October 17, 2012, at 11:00 a.m., in the MDS office, confirmed the resident's current nutritional status was inaccurate on the September 25, 2012, MDS assessment.	F 278		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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	445291	A. BUILDING _____ B. WING _____	10/13/2012

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F 280 SS=D	Continued From page 2 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to update the care plan to indicate changes in hospice status for one resident (#119) of thirty residents reviewed. The findings included: Resident # 119 was admitted to the facility on August 14, 2012, with diagnoses including Dementia with Behaviors, Confusion, and a History of Falls.	F 280	Resident # 19 now has the appropriate Hospice status noted on her care plan. All residents who are currently on routine Hospice or General Inpatient Hospice have the appropriate Hospice status noted on their care plan. Policies and procedures relating to the importance of addressing Hospice and the appropriate status of Hospice will be reviewed by the ADON on 10/25/12 and revised if necessary In-service will be completed on 10/25/12 by the ADON to the interdisciplinary team relating to the importance of addressing Hospice and the appropriate status of Hospice on the Care Plan. Audits will be completed by the QA Nurse on all resident s who are on Hospice to validate that Hospice is appropriately addressed on the Care Plan. This audit will begin on November 2, 2012. Any resident having a change in the type of Hospice or has a new order for Hospice care will be reviewed monthly to validate compliance on the Care Plan. The audit will be reviewed by the QA Committee on a monthly basis. The QA Committee members are the Administrator, Assistant-to-the-Administrator, Medical Director, Director of Nursing, Pharmacist, MDS Coordinator, Dietary Manager and Quality Assurance Nurse. When areas of focus and trends are identified, action plans will be completed.	11/16/12

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F 280	Continued From page 3 Medical record review of two physician's telephone orders (both undated) revealed an order to initiate GIP (General In Patient) hospice care and a later (undated) telephone order to discontinue the GIP level of hospice care. Medical record review of the resident's care plan dated August 14, 2012, did not indicate changes in the resident's level of hospice services. Interview with the Director of Nursing (DON) on October 17, 2012 at 9:00 a.m., in the conference room confirmed the resident's care plan did not reflect changes in the resident's level of hospice services.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and interview, the facility failed to follow care plan interventions for one (#126) of thirty sampled residents. The findings included: Resident #126 admitted to the facility on February 8, 2012, with diagnoses including Vascular Dementia, Anxiety, Depressive Disorder, and Chronic Obstructive Disorder.	F 282	Resident # 126 is currently kept in sight of staff when in wheelchair according to the Care Plan. All residents requiring staff observation while up in the wheelchair are appropriately observed The DON on 10/26/12 will review policies and procedures relating to appropriate observations while in wheelchairs. Revisions will be made if necessary. In-service will be completed on 10/30/12 by the DON for all staff relating to the importance of residents requiring appropriate observations of a resident while in wheelchairs. A make-up In-service will be completed on 11/2/12 The Quality Assurance Nurse on a weekly basis will complete an Audit for four weeks, every other week for one month, then monthly thereafter. This audit will consist of five observation per day of those residents requiring observation while up in wheelchairs.	11/16/12

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F 282	Continued From page 4 Medical record review of the Minimum Data Set dated October 2, 2012, revealed the resident has severe cognitive impairment and requires extensive assistance with all activities of daily living. Medical record review revealed the resident had a history of falls and following a fall from the wheelchair on September 17, 2012, the intervention added to the resident's plan of care was to, "keep the resident in sight of staff when in wheelchair." Observation on October 17, 2012, at 9:30 a.m., revealed the resident sitting alone in their room in a high/low wheelchair with an alarm and vest restraint in place. Interview with the Activity Director on October 17, 2012, at 9:40 a.m., confirmed the resident had been left alone in the resident's room, in a wheelchair and out of sight of staff.	F 282	The QA Committee on a monthly basis will review the audit. The QA Committee members are the Administrator, Assistant-to-the-Administrator, Medical Director, Director of Nursing, Pharmacist, MDS coordinator, Dietary Manager and Quality Assurance Nurse. When areas of focus and trends are identified, action plans will be developed and follow-u will be completed.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of the manufacturer's application instructions for vest	F 323	Resident # 50 and #126 currently have the vest safety device which he has applied correctly according to manufactures recommendations All residents currently requiring vest safety devices have the safety vests applied according to manufactures recommendations. Policies and Procedures relating to the appropriated application of the vest safety device will be reviewed by the DON on 10/26/12. Revisions will be made if necessary.	11/16/12

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F 323	Continued From page 5 restraints, and interview, the facility failed to correctly apply a vest restraint for two (#126 & # 50) of thirty sampled residents The findings included: Resident #126 admitted to the facility on February 8, 2012, with diagnoses including Vascular Dementia, Anxiety, Depressive Disorder, and Chronic Obstructive Disorder. Medical record review of the Minimum Data Set (MDS) dated October 2, 2012, revealed the resident has severe cognitive impairment and requires extensive assistance with all activities of daily living. Medical record review revealed the resident had a history of falls with many interventions attempted. Medical record review of nursing notes and review of facility documents revealed following a fall on September 12, 2012, an intervention to apply a vest restraint while the resident was in bed and in the wheelchair was put in place. Review of the vest restraint manufacturer application instructions for wheelchair use revealed: a. Position the patient as far back in the seat as possible with the buttocks against the back of the chair. b. Bring the straps over the hips at a 45-degree angle and pass down between the seat and the wheelchair sides. c. Criss-cross the straps, and use quick-release ties to attach straps to the opposite side kick spurs, out of the patient's reach.	F 323	In-Services will be provided for all staff on 10/30/12 relating to appropriate application of vest safety devices. This In-Service will be provided for all Staff unable to attend on 11/2/12. An audit will be completed on all residents requiring vest safety devices. The Quality Assurance Nurse will complete this audit. The audit will be completed weekly for the first month, every two weeks for the next month and monthly thereafter. The QA Committee on a monthly basis will review the audit. The QA Committee members are the Administrator, Assistant-to-the-Administrator, Medical Director, Director of Nursing, Pharmacist, MDS coordinator, Dietary Manager and Quality Assurance Nurse. When areas of focus and trends are identified, action plans will be developed and follow-u will be completed.	

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F 323	Continued From page 6 d. If the chair has an adjustable seat, secure straps to a movable part of the chair frame, out of the patient's reach. Further review revealed,"...a restraint applied incorrectly or worn backwards may result in serious injury or death..." Observation and interview with the Director of Nursing (DON) in the hallway on October 17, 2012, at 11:50 a.m., revealed the resident sitting in the hall in a high/low wheelchair wearing a vest restraint. Further observation revealed the straps came across the hips as directed however, the straps failed to be criss-crossed and attached to the kick spur as instructed. Interview with the DON at that time confirmed the restraint had been incorrectly applied. Resident #50 was readmitted to the facility on April 26, 2012, with diagnoses including Diabetes, Hyperlipederma, Hypertension, Dementia, and Anemia. Medical record review of the physician's orders dated August 3, 2012, revealed resident to have low rider wheelchair with a safety vest restraint and helmet. Observation on October 16, 2012, at 4:20 p.m., revealed the resident sitting in a wheelchair in the hallway wearing a safety vest restraint and helmet. Observation October 17, 2012, with registered nurse #1 (RN) at 10:45 a.m., at the nurses' station, of the resident sitting in the wheelchair, revealed the safety vest restraint tie straps came	F 323		

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F 323	Continued From page 7 across the hips as directed, however the straps failed to be criss-crossed and attached to back of wheelchair as instructed. Interview with the Director of Nursing on October 17, 2012, at 11:50 a.m., in the hallway, confirmed the safety vest restraint was incorrectly applied.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview the facility failed to ensure that kitchen equipment was properly sanitized. The findings included: Observation of the kitchen with the Dietary Manager on October 15, 2012, at 10:30 a.m., revealed the stove backsplash was covered with what was described by dietary aide #3 as; "gravy from the night before". Interview at this time with the Dietary Manager confirmed the stove backsplash was to be cleaned after use. Observation of the three compartment sink on	F 371	The stove backsplash was cleaned immediately and is currently on the daily cleaning schedule. Staff is currently dipping the dishes in the sanitizer per requirement for one minute. Strips are currently being utilized to determine the appropriate temperature is maintained for cleaning dishes. All policies and procedures relating to cleaning of the backsplash and appropriate cleaning of dishes will be reviewed by the Dietary Manager on 10/29/12. Revisions will be made if necessary. An In-Service was completed for dietary staff by the Dietary Manager on 10/16/12 relating to the daily cleaning schedules and the appropriate method for washing dishes. An In-service is to be held on 10/30/12 for those who were unable to attend on 10/16/12. An audit will be completed by the Quality Assurance Nurse to validate compliance. This audit will be completed daily for the first two weeks, every other day for the next two weeks, weekly for the next month and monthly thereafter.	11/16/12

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F 371	Continued From page 8 October 16, 2012, at 10:15 a.m., revealed dietary aide #2 washing and rinsing a strainer and two quarter pans and then dipping the items in sanitizer. Continued interview at this time with the Dietary Manager and dietary aide #1 and #2, revealed items are washed, rinsed, and dipped in the sanitizer. Review of the sanitizer information provided by the facility revealed " ...Surfaces must be wet at least 1 minute ..." Interview with the Dietary Manager in the kitchen, on October 17, 2012, at 8:30 a.m., confirmed the facility failed to properly sanitize cooking equipment in the three compartment sink by not ensuring proper contact time with the sanitizer.	F 371	The QA Committee on a monthly basis will review the audit. The QA Committee members are the Administrator, Assistant-to-the-Administrator, Medical Director, Director of Nursing, Pharmacist, MDS coordinator, Dietary Manager and Quality Assurance Nurse. When areas of focus and trends are identified, action plans will be developed and follow-up will be completed	
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to dispose of garbage and refuse properly. The findings included: Observation with the Dietary Manager on October 15, 2012, at 10:45 a.m., revealed the side of the outside garbage dumpster was covered with a heavy amount of food particles. Debris was also observed in the area surrounding the dumpster . Interview with the Dietary Manager at this time	F 372	Garbage is currently disposed of properly by the facility. All policies and procedures relating to proper disposal of garbage by the facility will be reviewed by the Dietary Manager on 10/30/12. Revisions will be made if necessary. In-Services was presented to all dietary staff on 10/16/12 on the proper disposal of garbage by the facility. This In-Service was completed by the Dietary Manager. An In-Service will be completed on 10/31/12 for those who could not attend on 10/16/12. An audit will be completed by the Quality Assurance Nurse to validate compliance. This audit will be completed daily for the Firs two weeks, every other day for the next tow weeks, weekly for the next month, and monthly thereafter. The QA Committee on a monthly basis will review the audit. The QA Committee members are the Administrator, Assistant-to-the-Administrator, Medical Director, Director of Nursing, Pharmacist, MDS coordinator, Dietary Manager and Quality Assurance Nurse. When areas of focus and trends are identified, action plans will be developed and follow-u will be completed	11/16/12

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F 372	Continued From page 9 confirmed the facility failed to dispose of garbage properly.	F 372		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain the kitchen walk in freezer in safe operating condition. The findings included: Observation on October 15, 2012, at 10:35 a.m., revealed the walk- in freezer door was bowed outward. Continued observation and inspection of the walk- in freezer revealed a heavy ice accumulation around the seal of the door. Interview at this time with the Dietary Manager confirmed that the door seal was not air tight causing the ice to form around the door.	F 456	The Walk-In freezer will have a new seal placed on the door on 11/5/12. Policies and procedures relating to the appropriate maintenance for the Walk-In freezer in safe operating condition will be reviewed on 10/30/12 by the Dietary Manger. Revisions will be made if necessary. In-Service was provided for the Dietary and Maintenance staff on 10/31/12 by Assistant-to-the-Administrator relating to appropriated maintenance for the Walk-In freezer. An In-service will be provided on 11/2/12 for those who could not attend. An audit will be completed by the Quality Assurance Nurse to validate compliance. This audit will be completed daily for the Firs two weeks, every other day for the next tow weeks, weekly for the next month, and monthly thereafter. The QA Committee on a monthly basis will review the audit. The QA Committee members are the Administrator, Assistant-to-the-Administrator, Medical Director, Director of Nursing, Pharmacist, MDS coordinator, Dietary Manager and Quality Assurance Nurse. When areas of focus and trends are identified, action plans will be developed and follow-u will be completed	11/16/12